

or political aspects of health care. Scientists and technologists have long recognized that they can communicate with one another and make progress only when the terms and symbols they use are clearly defined and the meaning clearly understood by all concerned. Symbolism and communication in the social, economic and political aspects of health care delivery systems or conduit have yet to become scientific in this very basic sense of precise definition of meaning.

The biblical tale told in the eleventh chapter of Genesis and the practical experience of modern science both seem to point to the same thing. We must first unconfound our language so that we can comprehend one another's speech. Only then can we understand one another and by working together make orderly progress toward the heavenly state of good health for all.

Abdominal Aortic Aneurysms

THE PAPER BY Moore and co-authors concerning misdiagnosis in patients with abdominal aortic aneurysms is particularly pertinent when reviewed in the context of the past 15 years of advance in vascular surgery. An untreated abdominal aneurysm is a lesion of a highly lethal potential. The mortality from elective aneurysmectomy by experienced vascular surgeons has shown a progressive decline from the original figures of 20 percent to the present norm of 2 to 4 percent. Yet during this same interval these surgeons have been unable to reduce the mortality for emergency aneurysmectomy for aortic rupture to below approximately 50 percent.

The need for diagnosis before rupture occurs is clear. Reliance upon the former textbook criteria where the diagnosis of aneurysm is suspected only if there exists a large pulsatile mass with pain

radiating to the back will allow most aneurysms to go to rupture undiagnosed. In this reviewer's experience with a large series of cases of ruptured aneurysms dealt with on an active vascular surgery service, in over 75 percent of the patients the diagnosis of aneurysm was not made before rupture. Most were free of symptoms until rupture occurred. Ninety percent of these patients had been examined by a licensed physician within the previous year.

The reason for the failure in early diagnosis became clear on review of the preoperative clinical events in the group of patients admitted for elective aneurysmectomy before rupture had occurred. In all of them the diagnosis had been first made by the referring physician. Forty percent of these patients, however, denied any form of abdominal symptoms other than a subjective throbbing sensation in the abdomen in those with particularly large aneurysms. Thirty percent had additional vague abdominal symptoms which prompted diagnostic investigation and from x-ray studies directed toward other organ systems the aneurysm became evident. In most of these patients, however, the size of the aorta could be accurately determined by careful abdominal palpation. That many of the lesions were first found by the radiologist suggests that thorough vascular examination is still omitted by some physicians.

The large number of patients in Dr. Moore's series in whom the diagnosis was missed by both the referring physician and the admitting physician in his own institution indicates that palpation for the size of the aorta was not included in the physical examination. Aortic rupture rarely occurs in aneurysms of less than 8 cm in diameter, yet the admitting physician failed to diagnose aortic rupture in four patients, and even the ward physician erred in three of these patients. Dr. Moore's message is clear and should be read by all members of the medical profession at large.